

stood by all his colleagues that his successful candidature for the psychiatry of old age post was merely a backdoor method of becoming a consultant.

As Dr Brook says in his article, not only are there 'a large number of applicants who seem to lack experience in geriatrics' but also 'the number of posts which were recorded by the College Assessors as having too large a commitment is alarmingly high, and there are indications that unsuitable posts are still being advertised'. They are. Yet the psychiatry of old age, in terms of sheer numbers of patients, is on the increase, and failure to tackle the problems of unsuitable jobs and poor candidates can only lower standards throughout psychiatry.

As it is easy to criticize, I would like to end with some thoughts on the basic requirements to make a post attractive.

It should have the majority of its time devoted to the elderly, and any other work allocated sessions should not be likely to grow to such an extent that it impinging on the services for the elderly.

There should be a reasonable share of the available beds, and some of these should be close to—or within—a department of geriatric medicine, and

preferably in a general hospital.

Day care facilities should exist—and not just buildings but staff and transport for patients.

A revenue sum should be available for the development of a community nursing service for the elderly.

There should be a base available, with an office for the person appointed and a revenue sum for the successful candidate to appoint a secretary of his own choosing who should also have an office next door to his; a telephone is a necessity, though often forgotten.

It should be clear, from the material sent to potential candidates, that an established psychogeriatrician had been involved with the planning—brought in from outside the Region if none existed inside. It should also be seen that a local geriatric physician was involved and was on the Advisory Appointments Committee.

The candidate, for his part, should be able to demonstrate, apart from general psychiatric competence, that he really is interested in old people, has worked for at least a short time in an established department for the psychiatry of old age, and knows of the existence of—and preferably has visited—a few other such departments in the country.

CORRESPONDENCE

THE FUTURE OF THE MENTAL HOSPITAL

DEAR SIR,

Several letters and articles published in *The Times* last year deplored the lack of psychiatric facilities. Topics covered the problem of accommodating disturbed patients in a District Hospital unit, the lack of community homes and the number of mentally ill offenders in prison. A note of despair linked the contributions, and with it there were urgent requests for new resources. Those of us struggling with Regional plans encounter similar problems: lip service is paid to the acute units in general hospital, to community treatment and local specialized units, but there is no money for such developments. An added assumption is that the large mental hospitals will gradually diminish and close and release much revenue. It is also so much nonsense. Money will not become available for expensive community facilities and only slowly for acute units. But buildings and resources do already exist in our mental hospitals to provide a comprehensive psychiatric service. To do so will require a change in viewpoint by our planners.

The invidious aspects of large psychiatric hospitals have been well publicized over the past 30 years, stemming from research work, descriptive accounts

and public inquiries. All have highlighted the dangers of a 'bad' institution. (The support for Regional secure units is all the more curious: that concept appears to embody all that is characteristic of a 'bad' institution, and it is unlikely to provide a solution to the problem of the mentally ill offender). Concurrently it became fashionable to discharge chronic patients to the community. A high discharge rate was seen as a therapeutic advance, but at times added nothing to the quality of a person's life. A further stage has been the preoccupation with therapeutic communities and, as a corollary, to have open wards. Some hospitals have made it a matter of policy to have no locked doors under any circumstances and have restricted their admissions. This occurs especially with mentally ill offenders. Another factor has been the development of psychiatric units in District General Hospitals and the difficulty of providing a service to a broad range of patients in these units. Inevitably, distinctions between such units and large psychiatric hospitals become emphasized, with at times an elitist view by patients and staff of the former. These various threads, woven together with, at times, emotive views, have produced a limited psychiatric service, one which reflects poorly on the profession.

We continue to read in the Press that large psychiatric hospitals imply incarceration, custodial care and increased dependency. These are dangers, but there are still many advantages in a larger hospital. It is often of a size to provide a range of facilities which can be used flexibly for patients. Psychiatric patients may well be disturbed on admission (and this includes mentally ill offenders), but with treatment this feature lessens. Thus, the patient can be moved to less secure wards, can be tried in various situations as part of rehabilitation, and so an orderly attempt can be made to return the patient to the community. But more is needed to maintain the morale and viability of mental hospitals. Already, many provide active and diverse treatment. Specialized units for alcoholism, for adolescents and rehabilitation would offset the more difficult and less glamorous tasks of caring for the elderly, the chronic and the disturbed. A further need is to link District General Hospital mental illness units with a large mental hospital. To emphasize the integration, staff, both medical and nursing, require to be appointed jointly to both hospitals. The emphasis is then on a comprehensive psychiatric service using the range of facilities as is appropriate to the patient. In this way distinctions would lessen.

Although this approach is practised here and there, much of the official planning still concentrates on the mental illness unit only, and views of the mid-60's still predominate. And so our large hospitals continue to deteriorate on the assumption they have no future. It is under such circumstances that scandals breed. A lead is required by both the College and the DHSS in using our current resources effectively and positively.

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TREATMENT WITHOUT CONSENT

DEAR SIR,

Counsel's Opinion (*Bulletin* February 1979, p. 21) on giving treatment to a detained patient without consent is interesting and helpful but does it go far enough? The advice that only in circumstances of urgent necessity should treatment other than observation be given to a patient admitted under Section 25 will make for difficulty in management, and applications to proceed to treatment under Section 26 will lead to delay and unnecessary suffering. It is disappointing that Counsel has not considered the role of the responsible medical officer, who is nowhere mentioned in the opinion.

The responsible medical officer in Section 59 (i) 'means (a) in relation to a patient liable to be detained by virtue of an application for admission for observation or an application for treatment, the medical

practitioner in charge of the treatment of the patient.' The definition is repeated in paragraph 23 of the 6th schedule. Attention should be given to the words 'responsible' and 'in charge of the treatment'. 'Responsible' means 'answerable, accountable (to another for something)' and 'capable of fulfilling an obligation or trust', according to the *Shorter Oxford English Dictionary*, and the same authority connects 'in charge of' with 'commission, and responsibility'.

It would seem, therefore, that Parliament had confidence in the judgment of the responsible medical officer not only in the matters of withholding unsuitable postal packets (Section 36), reclassification (Section 38), granting leave of absence (Section 39), authorizing discharge (Section 47), and restricting discharge by the nearest relative (Section 48), but also in the treatment of patients, consenting and non-consenting, detained under both Section 25 and Section 26.

I am sure that many clinicians will be interested in further discussion of this point.

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MENTAL HEALTH

DEAR SIR,

Some years ago, *The Journal of Mental Science* changed its name to *The British Journal of Psychiatry* and later 'The Royal College of Psychiatrists' became established.

Psychiatry has undergone considerable changes in a short span of time. Those working in the field for a relatively small number of years find many of their hallowed viewpoints and conceptions challenged and their original role less certain. Sociology, psychology and behavioural science have had a considerable influence on psychiatry. Regrettably 'Psychiatry' is still a term which has unfortunate connotations in lay circles.

This prompts the thought as to whether a change to the conception of 'Mental Health' would not be worth considering. This has the merit of emphasizing 'health' rather than illness and treatment. Specialist or Consultant in Mental Health might be the term adopted. Eventually the *Journal* might change its name if the trend found favour.

It would be interesting to know if others have thoughts on these lines.

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